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Vermont's All Payer ACO Model: Public Engagement to Inform a Potential Future Agreement

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Agenda

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1. A proposal for a subsequent agreement: should/how could we evolve this model?
2. Why is health care payment and delivery system reform important?
3. How is the implementation of VT's All-Payer ACO Model going?
    1. Early data and what we can say with it
    2. AHS's APM Implementation Improvement Plan
4. Requesting your advice…
5. Additional Resources

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Developing a proposal for a subsequent agreement

Key Terms

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- **Center for Medicare and Medicaid Innovation (CMMI)** - a division of U.S. Health and Human Services in charge of innovation, primarily focused on Medicare.
  - https://innovation.cms.gov/
- **State-Federal Agreement** - an agreement between CMMI and a state to create a geographically based payment and delivery reform model
- **Waiver** - an agreement between CMMI and the provider organization, which allows the provider to operate under different legal requirements than what is included in Medicare statute, rules, and guidance.

What authority does CMMI have?

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Sec. 1115A of SSA allows CMMI to:

1. Establish new payment models for Medicare, including through agreements with states (e.g. MD, PA, VT)
2. Waive some, but not all, federal requirements when tied directly to the payment/delivery system reform model
3. Increase benefits for Medicare beneficiaries, as long as this results in an overall savings to the Medicare Trust Fund

What authority is not provided?

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Under current law, CMMI cannot:

1. **Change** eligibility for Medicare;
2. **Reduce** benefits for Medicare beneficiaries;
3. **Change** cost-sharing for Medicare beneficiaries;
4. *Probably*, **include** prescription drugs in the model, due Part D benefits being administered by private companies.

Section 1115A is only Medicare focused. Agreements with other federal agencies are not included (e.g. Medicaid, Vermont Health Connect, etc)

Federal Requirements for Approval

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1. The model must save the Medicare program money while maintaining or increasing quality over the course of the model.
2. Agreements tend to span 5 years, with option for renewal
3. CMMI will take the following into consideration when approving a model:
    1. Monitoring and updating care plans
    2. “Patient centered”
    3. In-person contact with individuals
    4. HIT used
    5. Care coordination
    6. Team-based approach
    7. Information sharing

Should/how could Vermont evolve its agreement with CMS?

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1. Proposal for a subsequent agreement to engage with Medicare as Vermont aims to control health care cost growth and improve quality and population health (due to CMMI December 2021)
2. Should/how should we integrate Medicaid mental health, substance use disorder services, and long-term care services into TCOC (now due December 2021)

Vermont's All-Payer ACO Model within health care reform

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1. Health Care Financing

2. Health Care Coverage

3. Payment Reform – Curb Health Care Cost Growth

4. Delivery System Reform – Improve Quality and Population Health

Next Steps

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1. Public engagement prior to proposal development
    1. GMCB's General Advisory (Today)
    2. GMCB's Primary Care Advisory Group
    3. DVHA's Medicaid and Exchange Advisory Committee
    4. Targeted outreach to provider organizations (as COVID allows), advocates etc.
    5. Public Forum/Open Special Public Comment Period
2. Proposal development
    1. Governor/AHS/GMCB consider public feedback and draft preliminary proposal
    2. Public presentation of proposal to the GMCB
    3. Open Second Special Public Comment Period
    4. GMCB votes on proposal
    5. Signatories (Governor, AHS, GMCB) submit proposal to CMMI/CMS
3. Contract negotiations begin between three signatories and CMMI/CMS

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Why is Health Care Payment and Delivery System Reform Important?

Problem: Cost Growth is Unsustainable, and Health Outcomes Must Improve

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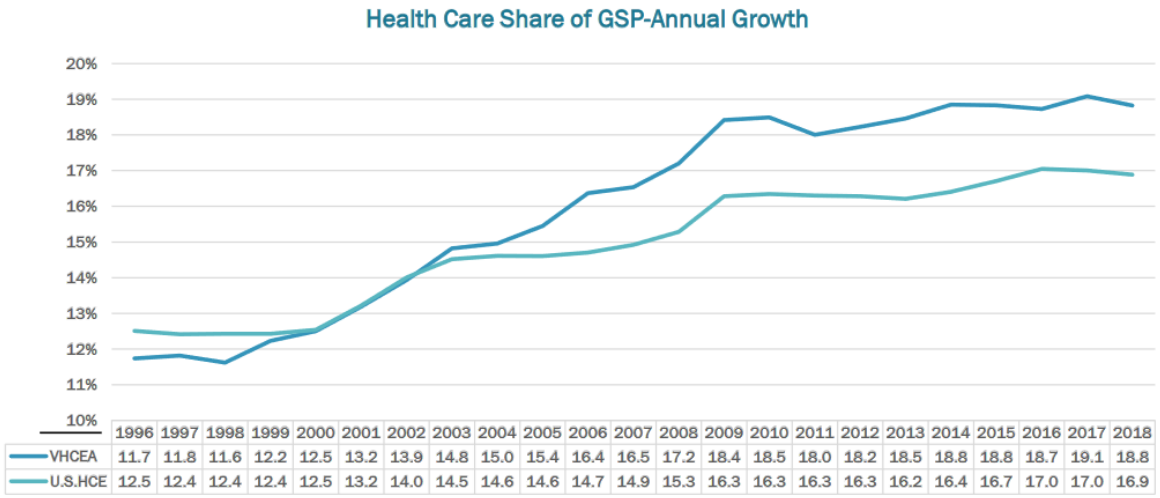
Cost Growth

- From 2013 through 2018, health care spending in Vermont grew more than **118%**.
- Vermont's health care share of state gross product devoted to health care spending was **18.8%** in 2018, vs. **16.9%** in 1995.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
VHCEA	11.7	11.8	11.6	12.2	12.5	13.2	13.9	14.8	15.0	15.4	16.4	16.5	17.2	18.4	18.5	18.0	18.2	18.5	18.8	18.8	18.7	19.1	18.8
U.S.HCE	12.5	12.4	12.4	12.4	12.5	13.2	14.0	14.5	14.6	14.6	14.7	14.9	15.3	16.3	16.3	16.3	16.3	16.2	16.4	16.7	17.0	17.0	16.9

Source: 2018 Vermont Health Care Expenditure Analysis, available at https://gmcboard.vermont.gov/data-and-analytics/analytics-rpts.

Health Outcomes

- Chronic diseases are the most common cause of death in Vermont.
  - High Blood Pressure: 25% of Vermonters diagnosed (2018)
  - Diabetes: 9% of Vermonters diagnosed (2018)
  - COPD: 6% of Vermonters diagnosed (2018)
  - Obesity: 29% of Vermont adults diagnosed (2018)
- Vermont's **death rates from suicide and drug overdose** are higher than the national average
  - Suicide (2017): 18.8 per 100,000 (VT)
  - Drug Overdose (2018): 159 Vermont Residents (VT)

Sources: Vermont Department of Health, Kaiser Family Foundation

CMS Moving Away from FFS

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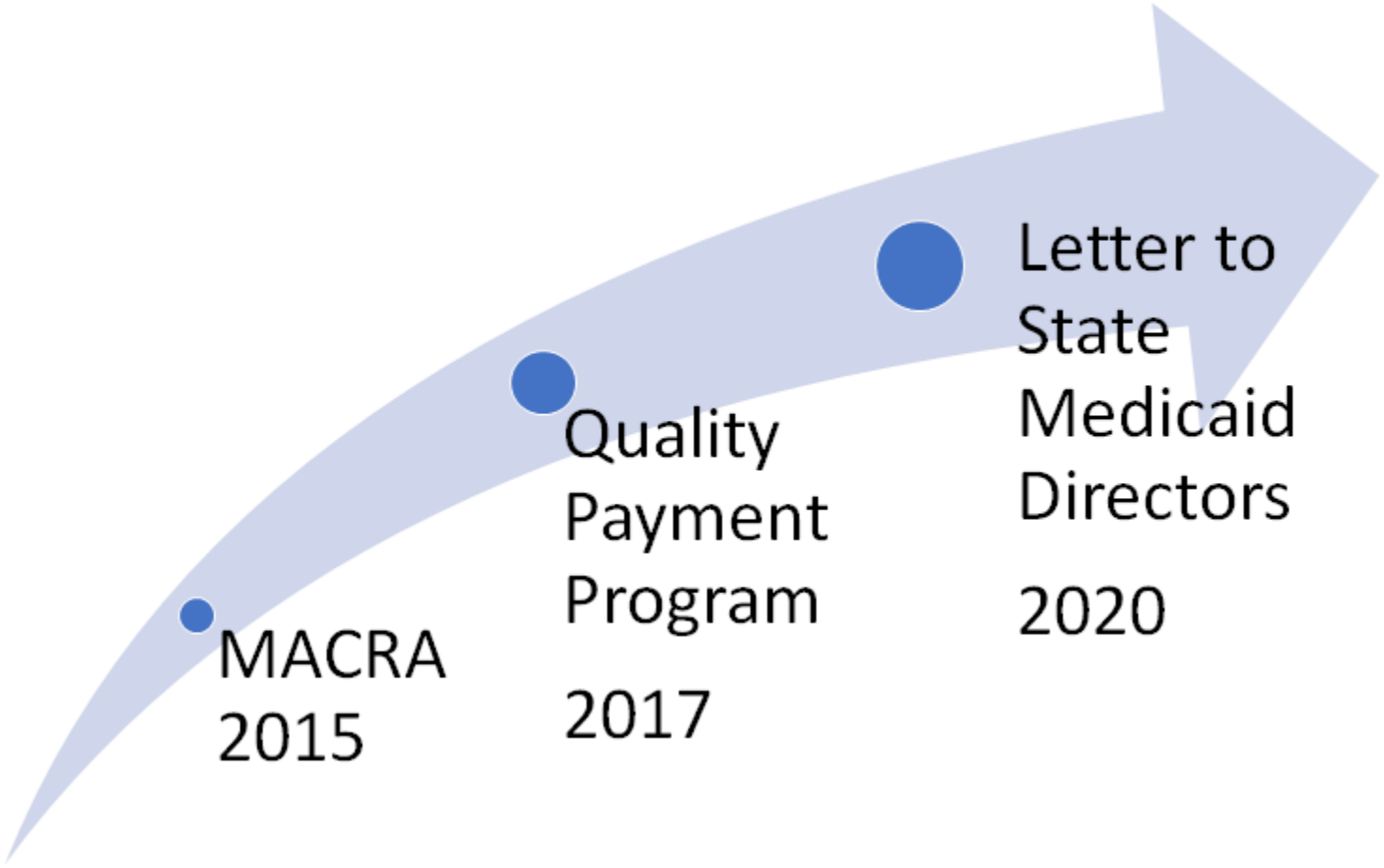

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How is the implementation of Vermont's All-Payer ACO Model going?

Measuring progress toward goals of Vermont's All-Payer Model Agreement

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Scale: Payer & Provider Participation

1. Assess alignment across **ACO-payer** programs and determine if scale qualifying

2. Track **providers** participating in qualifying programs

3. Measure scale by determining which **Vermonters "attribute"**: who is covered under a qualifying payer-program and has an established relationship with a participating provider?

Quality & Population Health Outcomes

Population health measures:

1. Improve access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Reduce the prevalence and morbidity of chronic disease

22 Quality measures expected to drive population health**:**

1. Health care delivery system quality targets
2. Process milestones
3. Population Health Outcomes

Health Care Cost Growth

Tracks per person spending on certain health care services known as the Total Cost of Care (TCOC).

Measures spending growth for **statewide all-payer** and **Medicare** populations:

1. Is all-payer spending on track to be less than 3.5% or 4.3% over the life of the agreement?
2. Is Vermont's Medicare spending more than 0.2% below the national average

VHCURES Data Timeline

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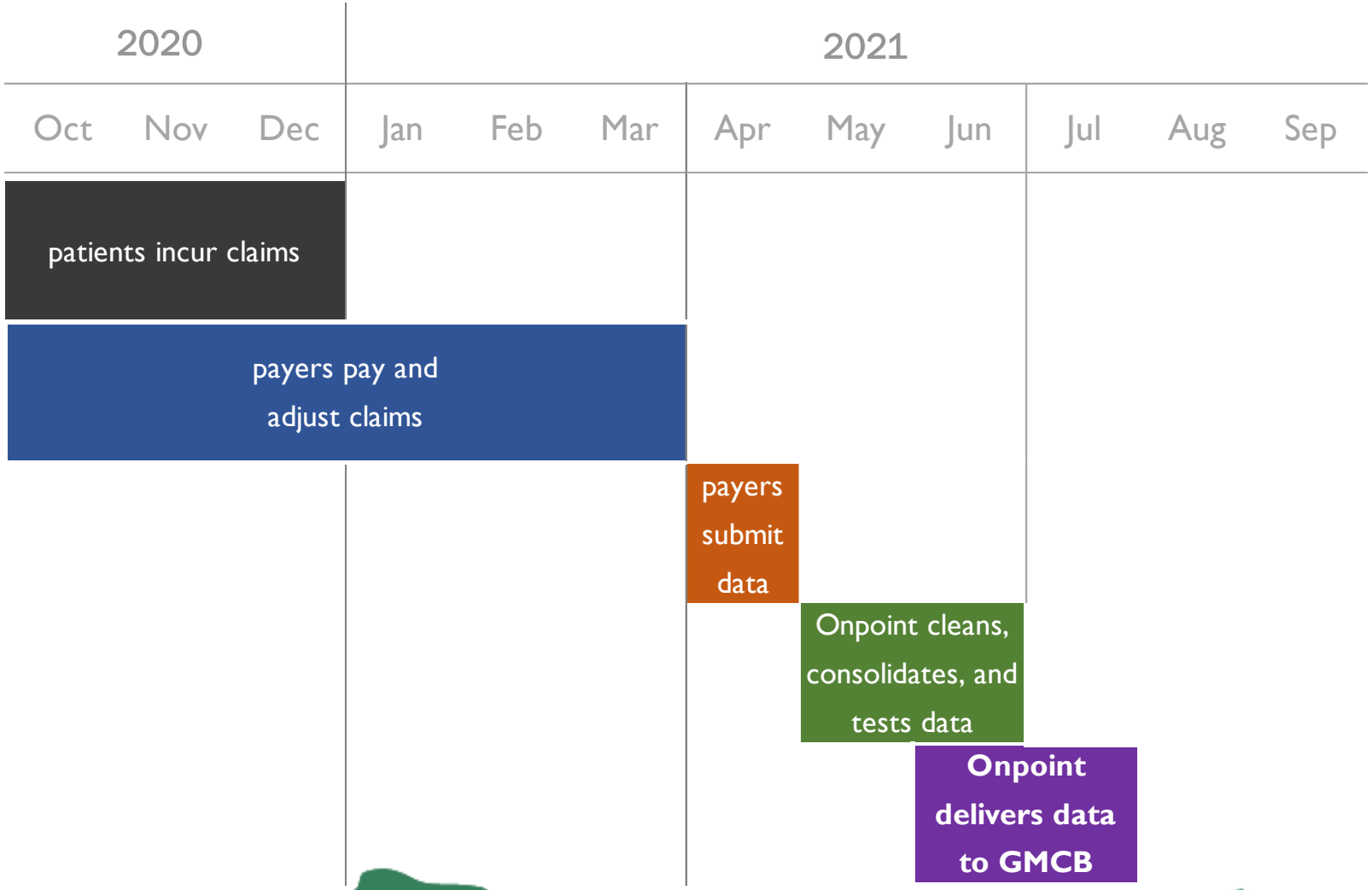

Measuring progress toward goals of Vermont's All-Payer Model Agreement

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Release of 2019 reporting on Quality & TCOC is now anticipated before March 2021 due to data delays associated with the COVID-19 Public Health Emergency (though data may still be incomplete and/or missing).

Scale: Payer & Provider Participation Growth

Medicare scale has grown 37% between 2018 and 2020, but is still short of the target, 44% vs 79%.

All-Payer scale has grown 103% between 2018 and 2020, but is still short of the target, 42% vs 58%.

Quality & Population Health Outcomes (2018)

- Making progress on 3/6 Population Health Outcomes Targets
- Moving toward achievement of 7/9 Healthcare Delivery System Quality Targets
- Making progress toward 6/7 Process Milestones

Health Care Cost Growth (2018)

2018: 4.1% All-Payer Growth

APM Implementation Improvement Plan (IIP)

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The Agency of Human Services issued a plan in November 2020 for improving performance in the All-Payer Agreement. The plan has four key categories of recommendations:

1. State/Federal work to maximize Agreement framework
2. Reorganization and prioritization of health reform activities within the Agency of Human Services
3. Evolving the regulatory framework for value-based payments
4. Strengthening ACO Leadership Strategy

Requesting your advice (in writing)…

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As a reminder…

This kind of agreement (1115A) **can**:

- Establish new payment models for Medicare, including through agreements with states (e.g. MD, PA, VT)
- Waive some, but not all, federal requirements when tied directly to the payment/delivery system reform model
- Increase benefits for Medicare beneficiaries, as long as this results in an overall savings to the Medicare Trust Fund

This kind of agreement (1115A) ***can't:***

- Change eligibility for Medicare;
- Reduce benefits for Medicare beneficiaries;
- Change cost-sharing for Medicare beneficiaries;
- Probably, include prescription drugs in the model, due Part D benefits being administered by private companies.

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Resource Slides

APM IIP: State/Federal Partnership

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Report Rec. Number	Activity: Federal/state Partnership	Timing*	Lead (s)	Agreement Domain Impact
1.	Negotiate with CMS to revise scale targets to reflect realistic capacity for participation.	Short-Term	AHS, GMCB	Scale, Financial, Quality
2.	Reduce Medicare risk corridor thresholds and decrease the financial burden of participation for hospitals.	Short-Term	AHS, GMCB	Scale, Financial, Quality
3.	Request that CMS establish written guidance or best practices in cost reporting for CAHs. GMCB should disseminate any guidance.	Short-Term	GMCB, AHS	Scale, Financial, Quality
4.	Establish a path for the Medicare payment model to mirror Vermont Medicaid Next Generation fixed prospective payments.	Short/Medium-Term	GMCB, AHS	Scale, Financial, Quality
5.	Ensure Medicare 2021 benchmark provides as much stability and predictability as possible despite the ongoing uncertainty associated with the pandemic.	Short-Term	AHS, GMCB	Scale, Financial, Quality
6.	Collaborate with CMMI to encourage Health Resources and Services Administration to prioritize Value-Based Payment for Federally Qualified Health Centers	Longer Term	AHS, GMCB	Scale, Financial, Quality

APM IIP: AHS Continuous Improvement

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Report Rec. #	Activity: AHS Prioritization and Reorganization	Timing	Lead (s)	Agreement Domain Impact
7.	AHS and the Agency of Administration will conduct education and outreach to non-participating self-funded groups about the benefits of participating in value-based payment models and Include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4).	Short/ Medium-Term	AHS	Scale Financial Quality
11.	Prioritize the integration of claims and clinical data in the HIE and organize and align the HIE with the Office of Health Care Reform within the AHS Secretary's office. Coordinate with the HIE Steering Committee.	Short/ Medium-Term	AHS	Quality Financial Scale
12.	Partner with OneCare Vermont and delivery system users to evaluate efficacy of Care Navigator platform.	Short/Medium-Term	AHS	Quality Financial
14.	Taking a phased approach, AHS will condition provider participation in the Blueprint for Health PCMH payments on participation in value-based payment arrangement with an ACO.	Longer Term	AHS	Financial Scale
15.	AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs. Organize VCCI and Blueprint for Health in Office of Health Reform in Secretary's Office.	Short-Longer Term	AHS	Quality Financial
16.	AHS, OneCare Vermont, and community provider partners should identify a timeline and milestones for incorporating social determinants of health screening into the standard of care in health and human services settings.	Short-Term	AHS	Quality Financial Scale
17.	AHS, through the Blueprint for Health, will jointly explore with OneCare Vermont and stakeholders the best available tools for capturing real-time patient feedback and to pilot such a methodology with willing primary care practices.	Longer Term	AHS	Quality
18.	AHS and the GMCB will prioritize regular stakeholder engagement opportunities.	Short-Term	AHS	Quality Financial Scale

APM IIP: Regulatory Continuous Improvement

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Report Rec. Number	Activity: Regulation	Timing	Lead (s)	Agreement Domain Impact
8.	The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.	Short/ Medium-Term	GMCB AHS	Financial
9.	Under authorities over both ACO and Hospital budgets, the GMCB should explore how ACO participants can move incrementally towards value-based incentives with the providers they employ.	Longer Term	GMCB	Financial Quality
10.	Annually, in its budget presentation to the Green Mountain Care Board, OneCare Vermont should identify cost growth drivers across its network and detail its approaches to curb spending growth and improve quality.	Short-Term	GMCB	Quality Financial Scale

APM IIP: Strengthening ACO Leadership Strategy

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Report Rec. #	Activity: Strengthening ACO Leadership Strategy	Timing	Lead (s)	Agreement Domain Impact
13.	OneCare Vermont should elevate data as value-added product for its network participants and support providers in leveraging the information for change.	Short/ Medium-Term	OneCare Vermont	Quality Financial Scale
Section II	Focus on entrepreneurship; how can an ACO ease providers' transition to value-based payment and delivery system redesign?	Short-Term	OneCare Vermont	Scale, Financial, Quality
Section II	Identify and perfect core business	Short-Term	OneCare Vermont	Scale, Financial, Quality
Section II	Provide useful, actionable information and tools to participating providers. OneCare should improve how it packages data for providers.	Short/ Medium Term	OneCare Vermont	Scale, Financial, Quality
Section II	Foster a culture of continuous improvement, innovation, and learning through focus on data, systems for improvement, and tracking of results.	Short-Term	OneCare Vermont	Scale, Financial, Quality
Section II	Improve transparency and responsiveness to partner requests for information.	Short-Term	OneCare Vermont	Scale Financial Quality

Agreement Targets: Scale

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Calculating All-Payer Scale

$$\frac{\textit{Vermont All-Payer Beneficiaries Aligned to a Scale Target ACO Initiative}}{\textit{Vermont All-Payer Scale Target Beneficiaries}}$$

- The Vermont All-Payer Scale Target denominator includes:
  - Medicare: All Vermont Medicare fee-for-service enrollees, including dual eligibles.
  - Medicaid: All Vermont Medicaid enrollees (excludes third-party coverage or limited benefit).
  - Commercial: All Vermont members of fully insured plans, self-funded employer plans, and Medicare Advantage plans (excludes members of Federal Employee Health Benefit Plans, TRICARE, and plans without a Certificate of Authority from Vermont Dept. of Financial Regulation; also excludes uninsured).

Calculating Medicare Scale

$$\frac{\textit{Vermont Medicare Beneficiaries Aligned to a Scale Target ACO Initiative}}{\textit{Vermont Medicare Beneficiaries (including dual eligibles, excluding Medicare Advantage)}}$$

All-Payer Scale

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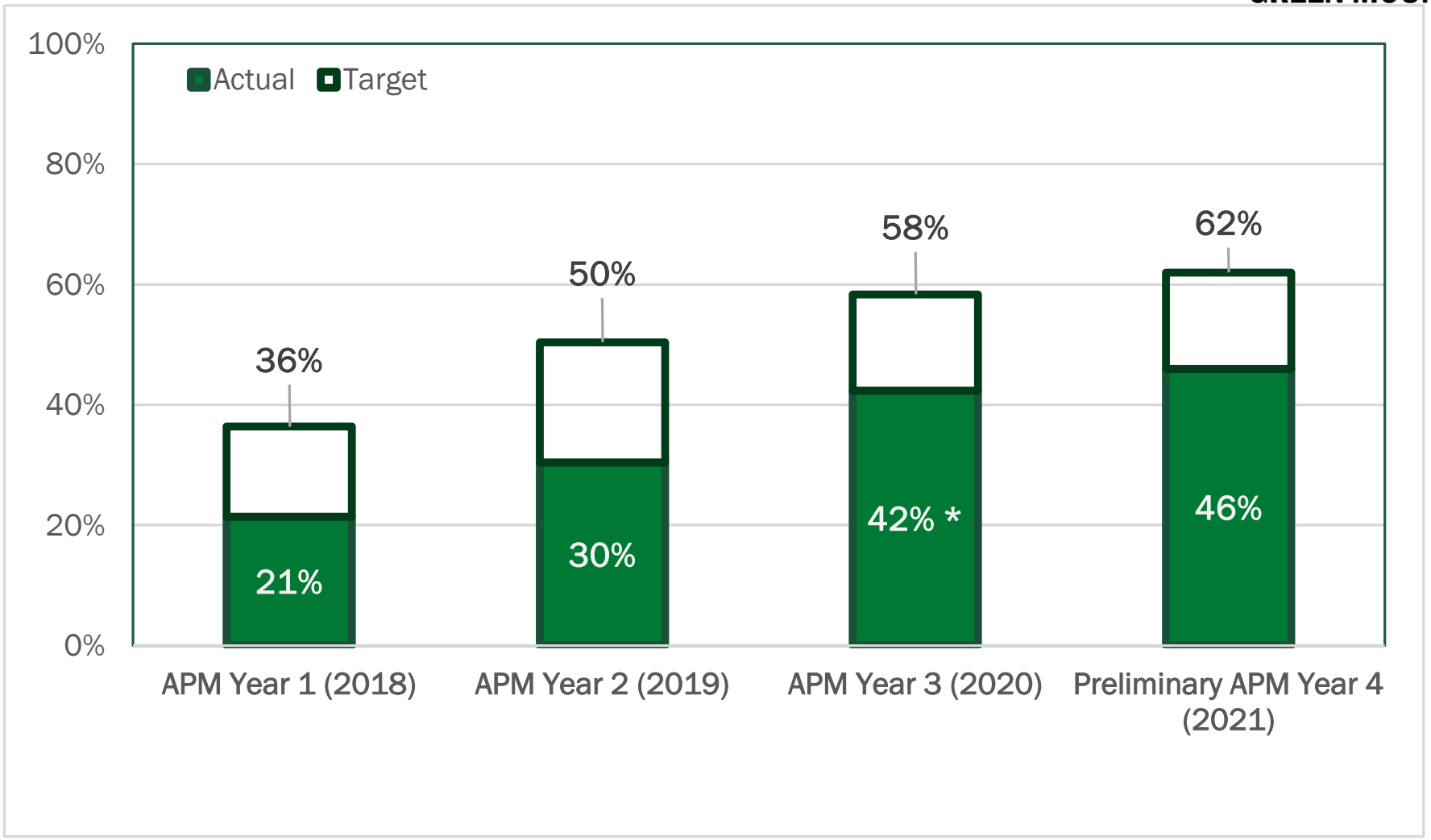

*Preliminary results based on attributions from payer contracts

All-Payer Scale x Payer Type

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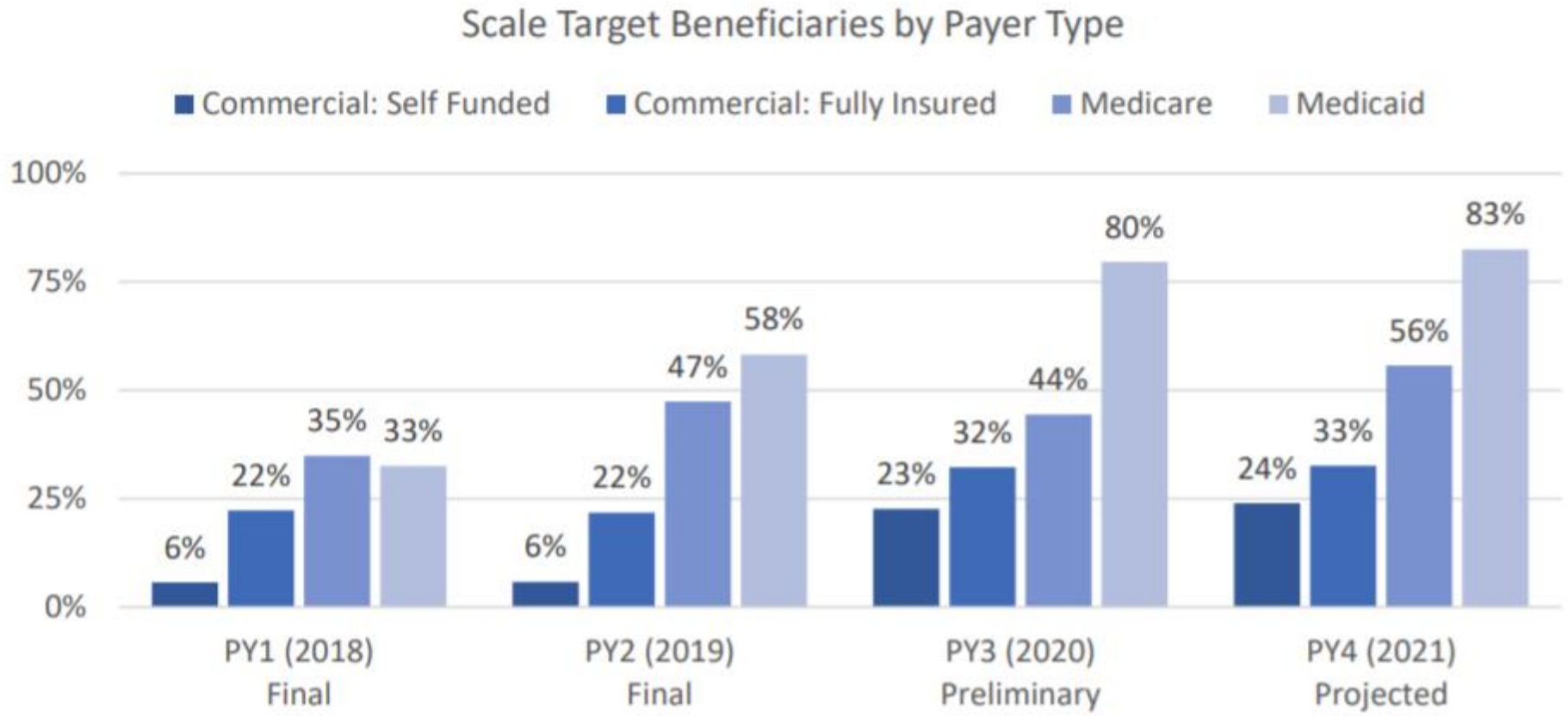

Medicare scale

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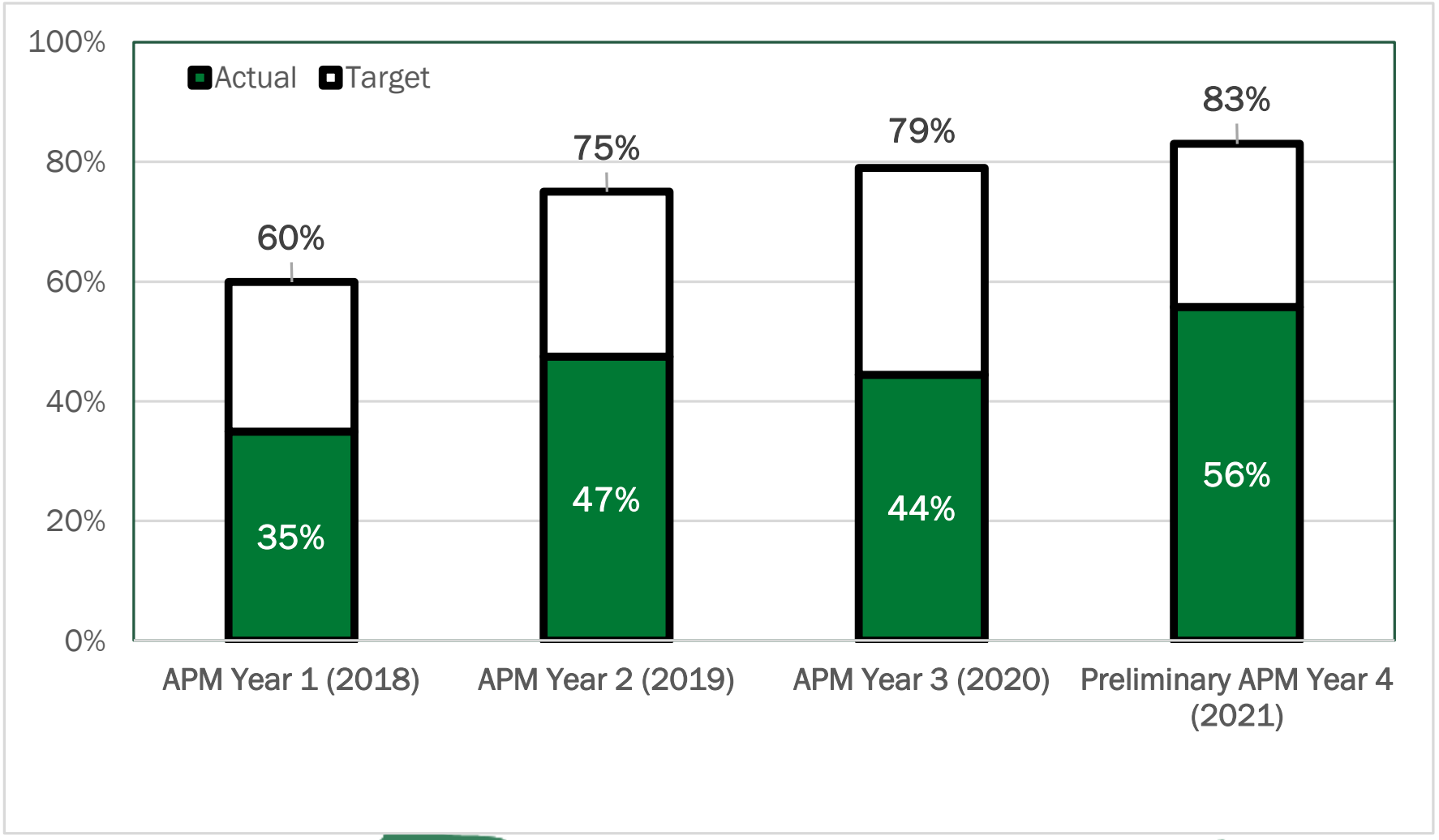

Comparing Measures of Health Care Spending

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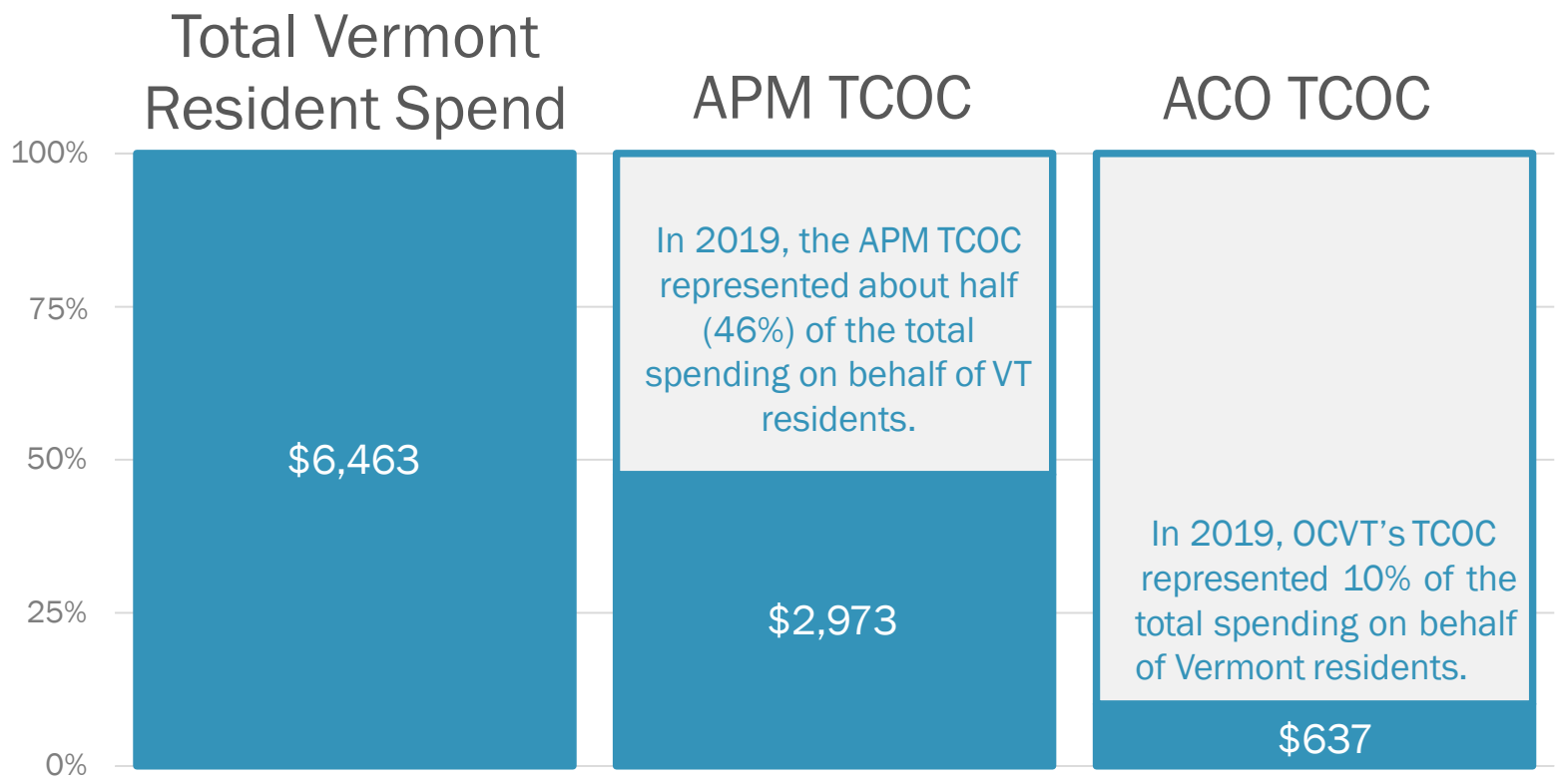

Notes: Spending above are in *millions* based on 2019 actuals for APM and ACO spending and estimated expenditures for total resident spend based on the Vermont Expenditure Analysis.

Agreement Targets: TCOC Growth

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The All-Payer ACO Model (APM) has two financial targets related to growth in the Total Cost of Care (TCOC), which are resident-based analyses. They measure how much the TCOC is changing on a per person basis for people who live in Vermont.

All-Payer TCOC Growth

- Target: Growth from 2017 to 2022 should be less than 3.5%, but no greater than 4.3% (triggering event).

Medicare TCOC Growth

- Target: Growth from 2017 to 2022 should be 0.2 percentage points less than expected national growth.

Agreement Targets: All-Payer TCOC Growth

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Vermont All-Payer TCOC per Beneficiary Growth will be calculated in aggregate as a compounded annualized growth rate across PYs 1-5, using 2017 as a baseline.

$$\frac{\textit{Vermont All-Payer TCOC}}{\textit{Vermont All-Payer TCOC Beneficiaries}}$$

Notes:

- The Vermont All-Payer TCOC numerator includes spending on Medicare Part A and B-equivalent services, though services vary somewhat by payer type. Payments include health care claims and some non-claims payments (prospective payments, shared savings payments, Blueprint for Health payments, etc.).
- The Vermont All-Payer TCOC denominator includes all insured Vermonters, excluding members of plans without a Certificate of Authority from the Vermont Department of Financial Regulation, and excluding self-funded employer plans that decline to submit data to Vermont's all-payer claims database, VHCURES.
- Cost data and denominator totals are derived from VHCURES.

Agreement Targets: Medicare TCOC Growth

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Vermont Medicare TCOC per Beneficiary Growth will be calculated as a compounded annualized growth rate across PYs 1-5, adjusting for the proportion of the population with end-stage renal disease.

In PY1-2 (and PY3, if Medicare scale target of 65% is not achieved):

$$\frac{\text{TCOC for Vermont Medicare Beneficiaries Aligned to a Scale Target ACO}}{\text{Vermont Medicare Beneficiaries Aligned to a Scale Target ACO}}$$

In PY4-5 (and PY3, if Medicare scale target of 65% is achieved):

$$\frac{\text{TCOC for All Vermont Medicare Beneficiaries}}{\text{All Vermont Medicare Beneficiaries (includes dual eligibles, excludes Medicare Advantage)}}$$

Notes:

- The Vermont Medicare TCOC numerator includes spending on Medicare Part A and B services.
- The Vermont Medicare TCOC denominator includes ACO-attributed Vermont Medicare beneficiaries in PY1-2 (and PY3 if Medicare scale target is not achieved). The Vermont Medicare TCOC denominator includes all Vermont Medicare beneficiaries in PY4-5 (and PY3, if Medicare scale is achieved).
- Data is obtained from CMS reports and validated using ACO reports and VHCURES.

Quality & Population Health Outcomes

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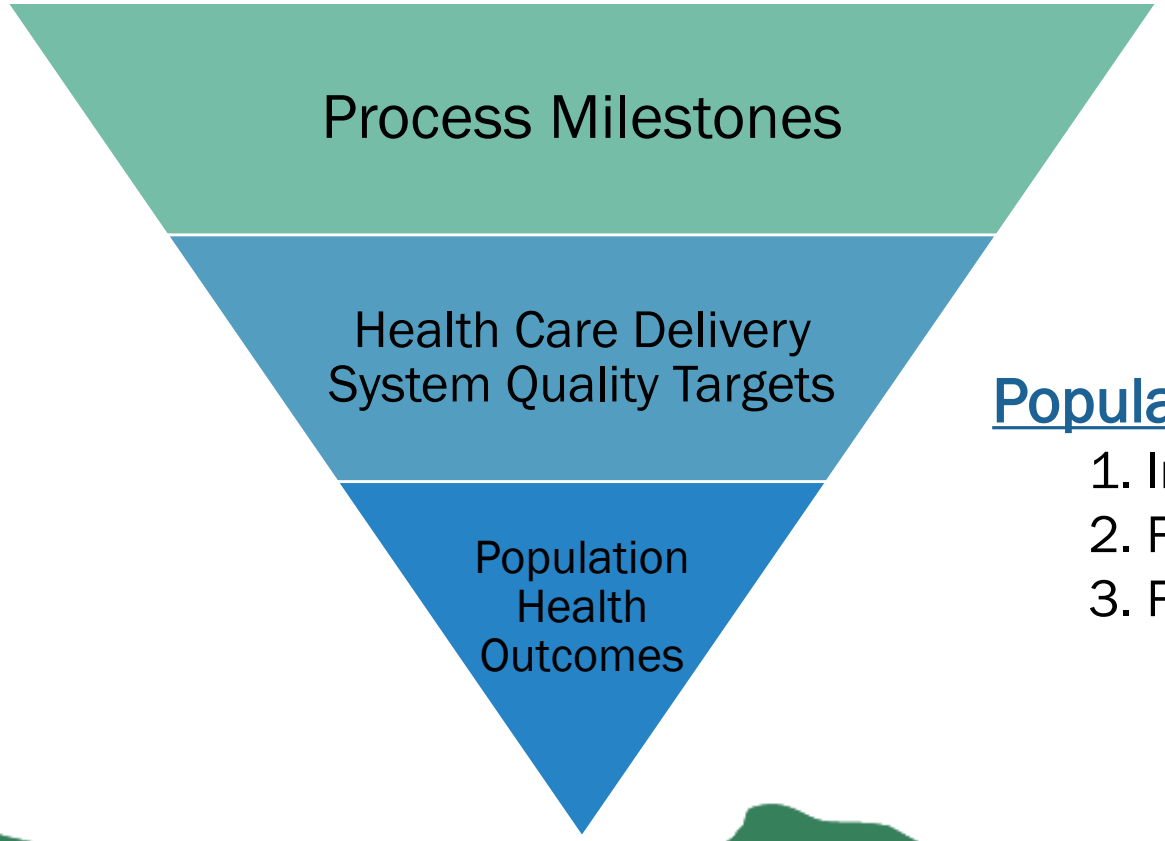
Vermont is responsible for meeting targets on **22 population health and quality measures** under the agreement; Process Milestones and Health Care Delivery System Quality Targets support achievement of ambitious Population Health Goals



Population Health Goals

1. Improve access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Reduce prevalence and morbidity of chronic disease